SERFF Tracking Number:	*WAKE-126046170*	*State:*	*Arkansas*
Filing Company:	*The Order of United Commercial Travelers of America*	*State Tracking Number:*	*41666*
Company Tracking Number:	*AMHSTCAR*		
TOI:	*H13I Individual Health - Short Term Care*	*Sub-TOI:*	*H13I.002 Nursing Home*
Product Name:	*Short Term Convalescent Care*		
Project Name/Number:	*UCT/AMHSTCAR*		

Filing at a Glance

Company: The Order of United Commercial Travelers of America

Product Name: Short Term Convalescent Care	SERFF Tr Num: WAKE-126046170	State: ArkansasLH
TOI: H13I Individual Health - Short Term Care	SERFF Status: Closed	State Tr Num: 41666
Sub-TOI: H13I.002 Nursing Home	Co Tr Num: AMHSTCAR	State Status: Approved-Closed
Filing Type: Form/Rate	Co Status:	Reviewer(s): Rosalind Minor
	Author: Toni Hess	Disposition Date: 08/05/2009
	Date Submitted: 02/25/2009	Disposition Status: Approved-Closed
Implementation Date Requested: On Approval		Implementation Date:

State Filing Description:

General Information

Project Name: UCT	Status of Filing in Domicile: Pending
Project Number: AMHSTCAR	Date Approved in Domicile:
Requested Filing Mode: Review & Approval	Domicile Status Comments:
Explanation for Combination/Other:	Market Type: Individual
Submission Type: New Submission	Group Market Size:
Overall Rate Impact:	Group Market Type:
Filing Status Changed: 08/05/2009	Explanation for Other Group Market Type:
	State Status Changed: 08/05/2009
Deemer Date:	Corresponding Filing Tracking Number:

Filing Description:

SUBMISSION

Short Term Care Insurance Policy – Form Number STC 1/09

Outline of Coverage – Form Number STC OC 1/09

Home Health Care Rider – Form Number STC HHC 1/09

Guaranteed Purchase Option Rider – Form Number STC GPO 1/09

SERFF Tracking Number:	*WAKE-126046170*	*State:*	*Arkansas*
Filing Company:	*The Order of United Commercial Travelers of America*	*State Tracking Number:*	*41666*
Company Tracking Number:	*AMHSTCAR*		
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Project Name/Number:	*UCT/AMHSTCAR*		

Compound Inflation Protection Rider – Form Number STC CI 1/09
Application – Form Number STC 1/09 AR
Replacement Form – Form Number REPL-STC

Wakely Actuarial Services, Inc. has been retained by The Order of United Commercial Travelers of America to file the above-captioned form on their behalf. We are requesting the review and approval of these forms. A letter of authorization is included for reference.

All required filing documents have been completed and are included with the filing.

The policy provides limited benefits for a short term confinement in a facility. Other benefits available are specified in the policy. Coverage is not intended to be long term care insurance according to you state's insurance laws and regulations.

The applicant will select a daily benefit amount from $50 to $300 with either a 0 or 20 day elimination period. The maximum benefit periods available to applicants will be 100, 200 or 360 days. The lifetime maximum benefit period will be three times the maximum benefit period selected.

To qualify for benefits an insured must be certified by a licensed health care practitioner as being unable to perform at least two of six activities of daily living (bathing, continence, dressing, eating, toileting and transferring) or requires substantial supervision to protect oneself from threats to health and safety due to severe cognitive impairment.

A period of care will begin the first day benefits are paid for a facility confinement (or the first day benefits are paid for either a facility confinement or receiving home health care, if the optional rider is selected. A period of care ends, if for a period of 180 consecutive days, the insured has not met the requirements of eligibility, a physician certifies that the insured does not require or has been required to be confined in a facility or been advised to receive home health care during the 180 day period and the insured has not been confined in a facility or receiving home health care services.

The covered services begin one the elimination period has been satisfied and pay actual charges incurred up to the daily benefit amount for each day of confinement in a facility.

SERFF Tracking Number:	*WAKE-126046170*	*State:*	*Arkansas*
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Optional riders which can be selected include a Home Health Care Rider, a Compound Inflation Protection Rider and a Guaranteed Purchase Option Rider.

The underwriting is on an accept/reject basis based on the criteria administered through the application and phone interviews. Premium rates are available for issue ages 50-85.

The policy and riders will be marketed by agents and brokers who are licensed in your state.

The actuarial memorandum and rates are also included with this filing.

Company and Contact

Filing Contact Information

(This filing was made by a third party - WAS01)

Toni Hess, Compliance Consultant
931 Clarmont Avenue
Bensalem, PA 19020

toni.hess@hesscc.com
(267) 523-5392 [Phone]

Filing Company Information

The Order of United Commercial Travelers of America
1801 Watermark Drive, Suite 100
P.O. Box 159019
COLUMBUS, OH 43215-8619
(800) 848-0123 ext. [Phone]

CoCode: 56383
Group Code: -99
Group Name:
FEIN Number: 31-4273120

State of Domicile: Ohio
Company Type:
State ID Number:

Filing Fees

Fee Required?	Yes
Fee Amount:	$100.00
Retaliatory?	No

SERFF Tracking Number:	*WAKE-126046170*	*State:*	*Arkansas*
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Fee Explanation:	$50 - Forms $50 - Rates
Per Company:	No

SERFF Tracking Number:	*WAKE-126046170*	*State:*	*Arkansas*
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COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
The Order of United Commercial Travelers of America	$100.00	02/25/2009	25973818

SERFF Tracking Number:	*WAKE-126046170*	*State:*	*Arkansas*
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Project Name/Number:	*UCT/AMHSTCAR*		

Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Rosalind Minor	08/05/2009	08/05/2009

Filing Notes

Subject	Note Type	Created By	Created On	Date Submitted
Status Request	Note To Reviewer	Toni Hess	07/23/2009	07/23/2009
Status Request	Note To Reviewer	Toni Hess	04/22/2009	04/22/2009

SERFF Tracking Number:	*WAKE-126046170*	*State:*	*Arkansas*
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Project Name/Number:	*UCT/AMHSTCAR*		

Disposition

Disposition Date: 08/05/2009
Implementation Date:
Status: Approved-Closed
Comment:

Toni - Sorry this one took too long to review. There was a mix up on who was suppose to review it.

Thanks for your patience.

Rate data does NOT apply to filing.

SERFF Tracking Number:	*WAKE-126046170*	*State:*	*Arkansas*
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Item Type	Item Name	Item Status	Public Access
Supporting Document	Flesch Certification	Approved-Closed	Yes
Supporting Document	Application	Approved-Closed	Yes
Supporting Document	Health - Actuarial Justification	Approved-Closed	No
Supporting Document	Outline of Coverage	Approved-Closed	Yes
Supporting Document	Authorization Letter	Approved-Closed	Yes
Form	Short Term Care Insurance Policy	Approved-Closed	Yes
Form	Home Health Care Rider	Approved-Closed	Yes
Form	Guaranteed Purchase Option Rider	Approved-Closed	Yes
Form	Compound Inflation Protection Rider	Approved-Closed	Yes
Form	Replacement Form	Approved-Closed	Yes

SERFF Tracking Number:	*WAKE-126046170*	*State:*	*Arkansas*
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Project Name/Number:	*UCT/AMHSTCAR*		

Note To Reviewer

Created By:

Toni Hess on 07/23/2009 12:18 PM

Last Edited By:

Rosalind Minor

Submitted On:

08/05/2009 02:15 PM

Subject:

Status Request

Comments:

Could I please get a status on this filing?

It has been open since February and there has been no activity.

Thank you

Toni Hess

SERFF Tracking Number:	*WAKE-126046170*	*State:*	*Arkansas*
Filing Company:	*The Order of United Commercial Travelers of America*	*State Tracking Number:*	*41666*
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Note To Reviewer

Created By:

Toni Hess on 04/22/2009 10:18 AM

Last Edited By:

Rosalind Minor

Submitted On:

08/05/2009 02:15 PM

Subject:

Status Request

Comments:

Could I please get a status on this filing?

Thank you.

SERFF Tracking Number:	*WAKE-126046170*	*State:*	*Arkansas*
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Form Schedule

Lead Form Number: STC 1/09

Review Status	Form Number	Form Type	Form Name	Action	Action Specific Data	Readability	Attachment
Approved-Closed	STC 1/09	Policy/Contract/Fraternal Certificate	Short Term Care Insurance Policy	Initial		42	STC 109.pdf
Approved-Closed	STC HHC 1/09	Policy/Contract/Fraternal Certificate: Amendment, Insert Page, Endorsement or Rider	Home Health Care Rider	Initial		47	STC HHC 109.pdf
Approved-Closed	STC GPO 1/09	Policy/Contract/Fraternal Certificate: Amendment, Insert Page, Endorsement or Rider	Guaranteed Purchase Option Rider	Initial		44	STC GPO 109.pdf
Approved-Closed	STC CI 1/09	Policy/Contract/Fraternal Certificate: Amendment, Insert Page, Endorsement or Rider	Compound Inflation Protection Rider	Initial		46	STC CI 109.pdf

SERFF Tracking Number:	*WAKE-126046170*	*State:*	*Arkansas*
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Project Name/Number:	*UCT/AMHSTCAR*		

Approved-Closed	REPL.STC	Other	Replacement Form	Initial	42	REPL STC.pdf

THE ORDER OF
UNITED COMMERCIAL TRAVELERS OF AMERICA
1801 WATERMARK DRIVE, SUITE 100, P.O. BOX 159019, COLUMBUS, OH 43215-8619
(614) 487-9680 • TOLL-FREE: (800) 848-0123 • FAX: (614) 487-9675 • www.uct.org

SHORT TERM CARE INSURANCE POLICY

THIS IS A LIMITED BENEFIT INSURANCE POLICY

THIS IS NOT A LONG TERM CARE INSURANCE POLICY ACCORDING TO STATE INSURANCE LAWS AND REGULATIONS

LIMITED BENEFITS ARE PROVIDED FOR SHORT TERM CONFINEMENT IN A FACILITY THAT PROVIDES NURSING CARE AND FOR OTHER BENEFITS SPECIFIED IN THE POLICY

THIS IS A LEGAL CONTRACT BETWEEN YOU AND US.

PLEASE READ THIS POLICY CAREFULLY. In the event You have any questions, need information or have a complaint regarding Your Policy, You may contact Us at Our Home Office: **1801 Watermark Drive, Suite 100, P.O. Box 159019, Columbus, Ohio 43215-8619, 1-800-848-0123**

This is a contract between You and The Order of United Commercial Travelers of America (UCT). We issue this Policy based on the application signed by You and the payment of premiums as stated on the Policy Schedule Page. We will pay the benefits subject to all the terms and conditions of this Policy. This Policy begins on the Policy Effective Date listed on the Policy Schedule Page. Payment of each premium as it comes due will continue coverage to the next premium due date.

Thirty Day Right To Examine and Return Policy

Please read Your Policy carefully. If, for any reason, You are not satisfied, You may return Your Policy to Us within thirty (30) days after receiving it. If returned, the Policy will be void from its beginning and any premium paid will be refunded.

Guaranteed Renewable For Life - Premium Subject To Change

This Policy is renewable as long as You live, provided You continue to pay premiums when due. At no time while You continue Your Policy in force, may We place any restrictive riders on Your coverage. We cannot cancel or refuse to renew this Policy. Your premiums will not increase due to a change in Your age or health. We can, however, change Your premiums but only if We change premiums for all policies in the same premium class with the same policy form number in Your state. We must give You at least [thirty (30)] days written notice before We change Your premiums.

CAUTION: The issuance of this insurance Policy is based upon Your responses to the questions on Your application. A copy of Your application is attached. If Your answers are incorrect or untrue, We may have the right to deny benefits or rescind Your Policy. The best time to clear up any questions is now, before a claim arises! If, for any reason, any of Your answers are incorrect, contact Us at Our Home Office at the following address: 1801 Watermark Drive, Suite 100, P.O. Box 159019, Columbus Ohio 43215-8619, 1-800-848-0123.

This is not a Medicare Supplement Policy: If You are eligible for Medicare, review the Guide To Health Insurance For People With Medicare available from Us.

Signed for the Society at Columbus, Ohio

Joseph H. Hoffman
Chief Executive Officer

Table of Contents

POLICY SCHEDULE PAGE

Insured: **Policy Effective Date:**

Policy Number: **Issue Age:**

Sex: **State of Issue:**

Mode At Issue: **Modal Premium:**

Premium Term: **Underwriting Class:**

****

		Premium
Short Term Care Insurance Policy:		**$**
Maximum Daily Benefit Amount:	**[$50 - $300 Daily]**	
Elimination Period	**[0 or 20] Days**	
Maximum Benefit Period	**[100, 200, 360] Days**	
Maximum Lifetime Benefit Period	**[300, 600, 1080 – 3 times the Maximum Benefit Period]**	

****

Optional Riders	**Premium**
Home Health Care Rider	**$**
5% Compound Inflation Rider	**$**
Guaranteed Purchase Option Rider	**$**
TOTAL PREMIUM	**$**

Policy Definitions

Activities of Daily Living means the basic human functions required for You to remain independent. For the purposes of this Policy, Activities of Daily Living are as follows:

1. **Bathing** means washing oneself by sponge bath; or in either a tub or shower; including the task of getting into or out of the tub or shower.
2. **Continence** means the ability to maintain control of bowel or bladder function; or, when unable to maintain control of bowel or bladder function, the ability to perform associated personal hygiene (including caring for catheter or colostomy bag).
3. **Dressing** means putting on and taking off all items of clothing and any necessary braces, fasteners or artificial limbs.
4. **Eating** means feeding oneself by getting food into the body from a receptacle (such as a plate, cup or table) after it has been prepared for You or by a feeding tube or intravenously.
5. **Toileting** means getting to and from the toilet, getting on and off the toilet, and performing associated personal hygiene.
6. **Transferring** means sufficient mobility to move into or out of a bed, chair or wheelchair or to move from place to place, either via walking, a wheelchair or other means.

Cognitive Impairment means a deficiency in a person's short or long-term memory, orientation as to person, place and time, deductive or abstract reasoning or judgment as it relates to safety awareness. Cognitive Impairment is measured by clinical evidence and standardized tests and is based on Your impairment as indicated by loss in the following areas:

1. short or long term memory; or
2. recognition of who or where You are; or time of day, month or year; or Your deductive or abstract reasoning.

Covered Services means confinement in a Facility (as defined in this Policy). Covered Services will be modified to include home health care, if the optional Home Health Care Rider is listed on the Policy Schedule Page and the premium for the Rider is paid.

Elimination Period means the number of Facility confinement days (or any combination of Facility confinement days and Home Health Care days, if the Home Health Care Rider is elected), for which benefits are not payable under this Policy. Days counted toward Your Elimination Period need not be consecutive. The Elimination Period is shown on the Policy Schedule Page. The Elimination Period must be satisfied only once during the Insured's lifetime and can only be satisfied by days on which You incur charges for which payment would be made under this Policy if there were no Elimination Period.

Facility means a facility that provides ongoing care and related services to at least five (5) inpatients in one (1) location and meets all of the following standards:

1. it is licensed by the appropriate licensing agency, if the state in which it operates licenses such facilities; and
2. it is operated pursuant to law; and
3. it is primarily engaged in providing, in addition to room and board accommodations, nursing care (skilled, intermediate or custodial) by or under the supervision of a duly licensed Physician; and
4. it provides twenty-four (24) hour a day care and services sufficient to support needs of persons who require nursing care; and
5. it has appropriate methods and procedures for handling and administering drugs and biologicals; and
6. it maintains a daily medical record of each patient.

A Facility includes a long term care facility, a nursing home facility or an assisted living facility.

A Facility IS NOT: a hospital, Your Home, and Alzheimer's Facility, an adult foster care facility, a facility or part thereof used primarily for rest; or a home or facility for the aged or for the care and treatment of drug and alcohol abuse; or a home or facility used for the care and treatment of Mental or Nervous Disorders or educational care.

Hands On Assistance means the physical assistance of another person without which You would be unable to perform an Activity of Daily Living.

Home means Your private residence, home for the retired or aged, or a place providing residential care, including an adult congregate living facility or a personal care facility.

Immediate Family means You and Your spouse, or the following relatives of You or Your spouse: parents, grandparents, brothers, sisters, children, grandchildren, aunts, uncles, cousins, nephews and nieces.

Lifetime Maximum Benefit Period means the maximum number of Facility confinement days (or any combination of Facility confinement days and Home Health Care days, if the Home Health Care Rider is elected) for which benefits are payable under this Policy. The Lifetime Maximum Benefit Period is shown on the Policy Schedule Page and is equal to three (3) times the Maximum Benefit Period.

Maximum Benefit Period means the maximum number of Facility confinement days (or any combination of Facility confinement days and Home Health Care days, if the Home Health Care Rider is elected) for which benefits are payable under this Policy per Period of Care. The Maximum Benefit Period is shown on the Policy Schedule Page.

Maximum Daily Benefit Amount means the maximum amount payable for any one day of benefits provided under this Policy. The Maximum Daily Benefit Amount is shown on the Policy Schedule Page.

Medicare means the Health Insurance for the Aged Act, Title XVIII of the Social Security Amendments of 1965 as then constituted or later amended, or Title I, Part I of Public Law 89-97, as enacted by the Eighty-Ninth Congress of the United States of America and popularly known as the Health Insurance for the Aged Act, as then constituted and any later amendments or substitutes thereof.

Mental or Nervous Disorder means a neurosis, psychoneurosis, psychopathy, psychosis, or mental or emotional disease or disorder. **NOTE: ALZHEIMER'S DISEASE AND OTHER ORGANIC BRAIN SYNDROMES ARE COVERED BY THIS POLICY AS ANY OTHER SICKNESS.**

Period of Care means the first day benefits are paid for a Facility confinement (or the first day benefits are paid for either, a Facility confinement or Home Health Care, if the optional Home Health Care Rider is elected). A Period of Care ends, if for a period of 180 consecutive days:

1. You have not met the requirements for benefit eligibility; and
2. Your Physician certifies that You did not require and have not been advised to be confined in a Facility or to receive Home Health Care for the 180 day period; and
3. You have not been confined in a Facility or received Home Health Care for the 180 day period.

Physician means a licensed practitioner of the healing arts operating within the scope of his or her license who is other than a member of Your Immediate Family.

Policy Anniversary Date means the same month and day as the Effective Date of this Policy for each succeeding year this Policy remains in force.

Standby Assistance means the presence of another person within arm's reach of You that is necessary to prevent, by physical intervention, injury to You while You are performing an Activity of Daily Living.

Substantial Supervision means continual supervision, which may include cueing by verbal prompting, gestures, or other demonstrations by another person that is necessary to protect You from threats to Your health or safety.

We, Our, Us, Society, UCT means The Order of United Commercial Travelers of America.

You, Your, Yourself means the Insured named on the Policy Schedule Page.

Qualifying For Benefits and Limitations On Benefits

Qualifying For Benefits

To receive benefits under this Policy, the following requirements must be met:

1. The Policy must be in force on the date Covered Services are received; and
2. A Physician must certify that:
   a) You are unable to perform at least two (2) Activities of Daily Living without Hands On Assistance or Standby Assistance; or
   b) You have a Cognitive Impairment and require Substantial Supervision.

Limitations On Benefits

Benefits under this Policy will not be paid during the Elimination Period and are subject to the Lifetime Maximum Benefit Period.

Benefits

Facility Confinement Benefit

Once the Elimination Period is satisfied under this Policy, We will pay the actual charges incurred up to the Maximum Daily Benefit Amount for each day You are confined in a Facility.

Bed Reservation Benefit

Once the Elimination Period is satisfied, We will pay the actual charges incurred up to the Maximum Daily Benefit Amount for fees charged to reserve a bed by a Facility when You are absent for any reason during the course of an eligible confinement. This benefit is limited to twenty-one (21) days per Period of Care. Benefits payments will count toward the Maximum Benefit Period.

Exclusions

We will not pay benefits for that portion of any expense which is:

1. caused by Mental or Nervous Disorder, without demonstrable organic disease **(NOTE: ALZHEIMER'S DISEASE AND OTHER ORGANIC BRAIN SYNDROMES ARE COVERED BY THIS POLICY AS ANY OTHER SICKNESS);** or
2. caused by alcoholism or drug addiction; or
3. caused by illness, treatment or medical conditions arising out of:
   a) war or act of war (whether declared or undeclared); or
   b) participation in a felony, riot or insurrection; or
   c) service in the armed forces or units auxiliary thereto; or
   d) suicide (while sane or insane), attempted suicide or intentionally self-inflicted injury; or
4. for treatment provided in a government facility (unless otherwise required by law), services for which benefits are available under Medicare or other governmental program (except Medicaid), any state or federal workers' compensation, employer's liability or occupational disease law, or any motor vehicle no-fault law; or
5. for services provided by a member of Your Immediate Family; or
6. for services for which no charge is normally made in the absence of insurance; or
7. for care received outside the United States or its territories.

General Provisions

Entire Contract; Changes: This Policy, including the application, endorsements and attached documents, if any, constitutes the entire contract of insurance. No change in this Policy shall be valid until approved by Our Chief Operating Officer and unless such approval shall be endorsed hereon or attached hereto. No agent or officer of any Local, Grand or Supreme Council has authority to change this Policy or to waive any of its provisions.

Time Limit On Certain Defenses: After three (3) years from the date of issue of this Policy no misstatements, except fraudulent misstatements, made by You in the application for the Policy shall be used to void the Policy or to deny a claim for loss incurred commencing after the expiration of the three (3) year period.

Grace Period: A grace period of thirty-one (31) days will be granted for the payment of each premium falling due after the first premium, during which grace period, this Policy shall continue in force.

Reinstatement: If any renewal premium is not paid within the time granted by Us for payment, a subsequent acceptance of any premium by Us or by any of Our authorized agents, without requiring an application for reinstatement, shall reinstate the Policy; provided, however that, if We or any of Our authorized agents require an application for reinstatement and issues a conditional receipt for the premium tendered, the Policy will be reinstated upon approval of such application by Us or, lacking such approval, upon the forty-fifth (45th) day following the date of such conditional receipt unless We have previously notified You in writing of Our disapproval of such application. The reinstated Policy shall cover only loss resulting from any accidental Injury as may be sustained after the date of reinstatement and loss due to such Sickness as may begin more than ten (10) days after that date. In all other respects We and You shall have the same rights thereunder as We and You had under the Policy immediately before the due date of the defaulted premium, subject to any provisions endorsed hereon or attached hereto in connection with reinstatement.

Notice of Claims: We must receive written notice of claim within twenty (20) days after any covered loss occurs or begins. If notice cannot be given at that time, it must be given as soon as reasonably possible. Notice may be given to the Society at Our Home Office at 1801 Watermark Drive, Suite 100, P.O. Box 159019, Columbus, Ohio 43215-8619 or to any of Our authorized agents, with information sufficient to identify You, shall be deemed notice to Us.

.

Claim Forms: When We get the notice, We will send You forms for filing proof of loss. If We do not send the forms within fifteen (15) working days after receiving written notice, Our requirements will be met if We receive written proof of the event and type and extent of the loss within the time stated below.

Proof of Loss: We must receive written proof of loss within ninety (90) days after the date the loss began or occurred. If it is not reasonably possible to give this timely proof, the claim will not be affected if it is sent as soon as is reasonable. However, unless the person making the claim is legally incapacitated, proof must be given within one (1) year from the time it is otherwise due.

Time of Payment of Claims: All benefits payable under this Policy will be payable immediately upon receipt of due written proof of such loss. For continuing losses, We will pay the benefits due monthly on receipt of due proofs of loss. All benefits due will be paid to You or to any health care provider to whom You have assigned benefits.

Payment of Claims: Any accrued benefits unpaid at Your death will be paid to Your estate or to any health care providers to whom You have assigned benefits. Should We fail to pay the benefits payable upon receipt of due written proof of loss, We shall have fifteen (15) working days thereafter within which to mail You a letter or notice which states the reasons We have for failing to pay the claim, either in whole or in part, and which also gives You a written itemization of any documents or other information needed to process the claim or any portions thereof which are not being paid. When all of the listed documents or other information needed to process the claim have been received, We shall then have fifteen (15) working days within which to process and either pay the claim or deny it, in whole or in part, giving You the reasons We may have for denying such claim or any portion thereof.

General Provisions Continued

Appeal of Denied Claims: If We deny a claim, We will notify You in writing. You will then have the right to appeal Our claims decision by writing to Us. In Your appeal, You should state why You disagree with Our decision to deny Your claim and state what other factors We should take into consideration. You will need to provide the names, addresses and telephone numbers of individuals who can be contacted for additional pertinent information. You should also provide the name, addresses and telephone numbers of the facilities where Your care was received and whom We can contact at these facilities to gather any information regarding Your care. You may authorize someone else to act for You in this appeal process.

Physical Examinations: At Our expense, We may have You examined as often as reasonably necessary while the claim is pending.

Legal Actions: No action at law or in equity shall be brought to recover on this Policy prior to the expiration of sixty (60) days after written proof of loss has been furnished in accordance with the requirements of this Policy. No such action shall be brought after the expiration of three (3) years after the time written proof of loss is required to be furnished.

Unpaid Premium: Upon the payment of a claim under this Policy, any premium then due and unpaid or covered by any note or written order may be deducted therefrom.

Pro Rata Refund: If We receive written proof of death which terminates coverage, We will refund that part of any premium You have paid which covers a period after death occurs.

Conformity With State Statute: Any provision of the Policy which, on its Policy Effective Date, is in conflict with the laws of the state in which You reside on such date is hereby amended to conform to the minimum requirements of such statutes.

Assignment: No assignment of any benefit or claim shall bind Us unless the same is filed in writing prior to the payment of any benefit claimed. We assume no responsibility for the validity of any assignment. Notice may be given to the Society at Our Home Office at 1801 Watermark Drive, Suite 100, P.O. Box 159019, Columbus, Ohio 43215-8619.

Clerical Error: Clerical error on Our part will not invalidate insurance otherwise in force nor continue insurance otherwise terminated. Upon discovery of any error, an equitable adjustment will be made in the premiums. Complete proof must be supplied, documenting any clerical errors.

Cancellation By Insured: You may cancel this Policy at any time by written notice delivered or mailed to Us, effective upon request or on such later date as may be specified in such notice. In the event of cancellation we shall make a pro-rata refund of any premium paid beyond the date of cancellation. Cancellation shall be without prejudice to any claim originating prior to the effective date of cancellation.

Owner Of Policy: The Insured shall be the Owner of this Policy. The Owner may exercise all options and rights under this Policy.

General Provisions Continued

Maintenance of Solvency: UCT's constitution provides that in the event that its reserves as to all or any class of contracts of insurance issued by it become impaired, the Board of Governors may require that these shall be paid by each owner of such contract of insurance to UCT an amount equal to such owner's equitable proportion of such deficiency as ascertained by the Board of Governors.
If payment of the amount required to be paid is not made by such owner, then either or both of the following, at the election of the owner, shall apply:

1. the amount shall stand as indebtedness against the contract of insurance and shall bear interest at a rate not to exceed ten percent (10%) per annum; or
2. the owner shall accept a proportionate reduction in benefits paid pursuant to the contract of insurance.

The owner shall make such election by notifying the Board of Governors of his or her election on a form prescribed by the Board of Governors that shall be provided to each owner. Failure to make such election shall result in a presumption that the owner elects to accept a proportionate reduction in benefits paid pursuant to the contract of insurance

You hereby agree that if You affirmatively elect to have the amount stand as indebtedness against the contract of insurance, then UCT may offset the amount of such indebtedness together with interest thereon against any payment of benefits to You or on Your behalf under the contract of insurance.

Suspension or Expulsion: If the Insured should be expelled or suspended from the membership in the Society for any reason, except for nonpayment of premium or within the contestable period for misrepresentation in the Insured's application for membership, the Insured shall have the privilege of maintaining this Policy in force by continuing payment of the required premium.

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HOME HEALTH CARE RIDER

Rider Effective Date:_____
(If other than the Effective Date of the Policy to which this Rider is attached.)

Rider Taking Effect and Renewal: We have issued this Rider in consideration of the payment of premium and the statements in the application. The application is part of the Policy to which this Rider is attached. The Effective Date of this Rider is the same as the Effective Date of the Policy to which this Rider is attached, unless otherwise indicated. You can keep this Rider in force, as long as You renew the Policy, by paying premiums as they become due.

This Rider is subject to all of the terms, provisions, definitions and exclusions of the Policy unless otherwise noted in this Rider. Information about Your Rider coverage, including its Effective Date and coverage limits are shown on the Policy Schedule Page.

Rider Premium: The Policy Schedule Page shows the premium for the Policy with the inclusion of this Rider. The same conditions that apply to changing premiums for the Policy apply to Our changing premiums for this Rider.

Right To Examine This Rider: If You are not satisfied with this Rider, return it to Us or to the agent from whom it was purchased. If returned within thirty (30) days from the date You received it, the Rider will be void as of the Rider's Effective Date, and all premiums paid for the Rider will be refunded.

This Rider is signed for the Society at Columbus, Ohio

Chief Executive Officer

Home Health Care Benefit

Home Health Care Benefit

Once the Elimination Period is satisfied under the Policy, We will pay 100% of the actual charges incurred up to the Maximum Daily Benefit Amount for each day You incur charges for Home Health Care or Adult Day Care. The number of days for which Covered Services are received under this Rider will be counted toward the Maximum Benefit Period for the Policy and is shown on the Policy Schedule Page.

The following requirements must be met to be eligible for the Home Health Care Benefit:
A Physician must certify in a Plan of Care that:

1. You are unable to perform at least two (2) Activities of Daily Living without Hands On Assistance or Standby Assistance; or
2. You have a Cognitive Impairment and require Substantial Supervision.

Home Health Care does not include services provided while confined in a hospital, long term care facility, an assisted living facility, a hospice care facility, or any other facility that charges room and board.

Respite Care Benefit

We will pay the one hundred percent (100%) of the actual charges incurred up to the Maximum Daily Benefit for Respite Care. The benefit is limited to thirty (30) days per Period of Care. Benefits payments will count toward the Maximum Benefit Period. Benefits for Respite Care are not payable if You are eligible or are receiving other benefits under this Rider or to the Policy to which this Rider is attached. The benefit is not subject to, nor may it be used to satisfy, the Elimination Period.

Definitions

Adult Day Care means a licensed or certified program for six (6) or more individuals of social and health-related services provided during the day in a community group setting for the purpose of supporting persons who can benefit from care in a group setting outside the Home.

Adult Day Care Center means an organization that provides a program of Adult Day Care and that meets the following requirements:

1. it is established and operated as an Adult Day Care Center in accordance with any applicable state or local laws including the laws requiring Adult Day Care Centers to be licensed; and
2. its staff includes
    a. a full-time director; and
    b. one (1) or more registered professional nurses (RN) in attendance for at least four (4) hours during operating hours; and
    c. not less than two (2) full-time staff members; and
3. it operates at least five (5) days a week for a minimum of six (6) hours per day, but is not an overnight facility; and
4. it maintains a written record of medical services given to each client; and
5. it has established procedures for obtaining appropriate aid in the event of a medical emergency.

Home Health Aide: An individual who provides Homemaker Companion Services, Hands On Assistance or Standby Assistance with Activities of Daily Living or Substantial Supervision when You have a Cognitive Impairment. The Home Health Aide must be employed by a Home Health Care Agency and licensed in the state or recognized in the state in which the care is given.

Home Health Care: Medical and nonmedical services provided by a Home Health Care Practitioner in Your Home, Adult Day Care received in an Adult Day Care Center and Homemaker Companion Services provided by a Homemaker Companion in Your Home. An expense for Home Health Care is incurred on the date the service is performed.

Home Health Care Agency: An agency or organization which:

1. specializes in giving nursing care or therapeutic services in the Home; and
2. is licensed to provide such care by the appropriate state licensing agency or authority where the services are performed or is Medicare certified as a Home Health Care Agency; and
3. maintains a complete medical record and plan of care on each patient; and
4. is operating within the scope of its license or certification.

Home Health Care Practitioner: An individual listed below who is qualified to provide Home Health Care in Your Home. A Home Health Care Practitioner is a Home Health Aide; a provider of medical or social services; a registered professional nurse (RN); a licensed practical nurse (LPN); a licensed vocational nurse (LVN); a licensed speech therapist or audiologist; a licensed respiratory therapist; a licensed physical therapist; a licensed chemotherapy specialist; or a licensed nutritional therapist. A Home Health Care Practitioner whose specialty is not listed here may be used if approved by Us prior to the practitioner providing the service. A Home Health Care Practitioner:

1. must be recognized in the state in which the care is given; and
2. may not be a member of Your Immediate Family; and
3. may not reside at Your address; and
4. must present a charge for the care given which You are legally obligated to pay; and
5. must be employed or contracted with a Home Health Care Agency.

Definitions Continued

Homemaker Companion: An individual who provides Homemaker Companion Services and is employed by a Home Health Care Agency and licensed in the state or recognized in the state in which the care is given.

Homemaker Companion Services: Homemaker Companion Services are as follows:

1. cooking, which means preparation of meals and nutrition; and
2. shopping, which means purchasing groceries, household supplies and medicine; and
3. assisting with the use of the telephone, laundering clothes, bill paying and other housekeeping tasks.

Homemaker Companion Services do not include any type of construction, renovation or maintenance (such as painting, etc.), lawn care, snow removal, maintenance of a vehicle or other similar services.

An expense for Homemaker Companion Services is incurred on the date the service is performed.

Plan of Care: A written document prepared and signed by a Physician which specifies the type and frequency of all care or services required by You. The written Plan of Care must include:

1. Physician's orders; and
2. the diagnosis and symptoms; and
3. the reasons for admission or required services; and
4. the frequency of care and type of treatment; and
5. the objective of the plan.

We reserve the right to require a Plan of Care be updated monthly, when it is determined to be reasonably necessary.

Respite Care: A service which temporarily relieves an unpaid person who is providing You with care in Your home or another private residence. Only the following services are Respite Care:

1. assistance with Activities of Daily Living; or
2. maintenance of the home environment to include the following services: shopping, meal planning, meal preparation, and light housekeeping; or
3. personal supervision for the protection of a cognitively impaired person.

Respite Care must be provided by a Home Health Care Agency unless pre-approved by Us..

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GUARANTEED PURCHASE OPTION RIDER

Rider Effective Date:_____
(If other than the Effective Date of the Policy to which this Rider is attached.)

Rider Taking Effect and Renewal: We have issued this Rider in consideration of the payment of premium and the statements in the application. The application is part of the Policy to which this Rider is attached. The Effective Date of this Rider is the same as the Effective Date of the Policy to which this Rider is attached, unless otherwise indicated. You can keep this Rider in force, as long as You renew the Policy, by paying premiums as they become due.

This Rider is subject to all of the terms, provisions, definitions and exclusions of the Policy unless otherwise noted in this Rider. Information about Your Rider coverage, including its Effective Date and coverage limits are shown on the Policy Schedule Page.

Rider Premium: The Policy Schedule Page shows the premium for the Policy with the inclusion of this Rider. The same conditions that apply to changing premiums for the Policy apply to Our changing premiums for this Rider.

Right To Examine This Rider: If You are not satisfied with this Rider, return it to Us or to the agent from whom it was purchased. If returned within thirty (30) days from the date You received it, the Rider will be void as of the Rider's Effective Date, and all premiums paid for the Rider will be refunded.

Guaranteed Purchase Option Benefit

If this Rider is shown on the Policy Schedule Page, on each third (3rd) Policy Anniversary Date You have the option to purchase additional amounts of coverage, with no evidence of insurability. The purchase of additional amounts of insurance is subject to the following conditions:

1. The Policy must be in force on the Policy Anniversary Date.
2. We will notify You sixty (60) days prior to the Policy Anniversary Date. You must notify Us in writing within thirty-one (31) days of (before or after) the Policy Anniversary Date if You wish to purchase the additional insurance. If You do not notify Us within this period, or if You do not purchase additional insurance on each third (3rd) Policy Anniversary Date, this benefit terminates and no future options can be used to purchase additional insurance.
3. The amount of additional insurance that can be purchased on each third (3rd) Policy Anniversary Date is fifteen percent (15%) of the Maximum Daily Benefit Amount in effect on the Policy Effective Date. Amounts greater than or less than fifteen percent (15%) may not be purchased under this provision. We will send You written notification of the revised premium and Maximum Daily Benefit Amount.
4. The premium for the additional insurance will be Our rates in effect on the date of purchase, and will be based upon Your attained age on the date of the purchase.
5. The additional insurance will have the same Maximum Benefit Period and Elimination Period as stated in the Policy Schedule.
6. No additional purchase options are available after age eighty-five (85).
7. No additional purchase options are available if You are on claim or eligible for benefits.

Termination: This Rider will terminate on the earliest of: (1) the end of the Grace Period while the premium due for the Policy or this Rider remains unpaid; or (2) the date Your Policy terminates; or (3) upon Your written request for termination of this Rider.

This Rider is signed for the Society at Columbus, Ohio

Joseph H. Hoffman
Chief Executive Officer

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COMPOUND INFLATION PROTECTION RIDER

Rider Effective Date:_____
(If other than the Effective Date of the Policy to which this Rider is attached.)

Rider Taking Effect and Renewal: We have issued this Rider in consideration of the payment of premium and the statements in the application. The application is part of the Policy to which this Rider is attached. The Effective Date of this Rider is the same as the Effective Date of the Policy to which this Rider is attached, unless otherwise indicated. You can keep this Rider in force, as long as You renew the Policy, by paying premiums as they become due.

This Rider is subject to all of the terms, provisions, definitions and exclusions of the Policy unless otherwise noted in this Rider. Information about Your Rider coverage, including its Effective Date and coverage limits are shown on the Policy Schedule Page.

Rider Premium: The Policy Schedule Page shows the premium for the Policy with the inclusion of this Rider. The same conditions that apply to changing premiums for the Policy apply to Our changing premiums for this Rider.

Right To Examine This Rider: If You are not satisfied with this Rider, return it to Us or to the agent from whom it was purchased. If returned within thirty (30) days from the date You received it, the Rider will be void as of the Rider's Effective Date, and all premiums paid for the Rider will be refunded.

Compound Inflation Protection Benefit

At 12:01 A.M., Standard Time at Your place of residence on the first Policy Anniversary Date of the Policy after the Rider's Effective Date and on each subsequent Policy Anniversary Date, We will automatically increase the Maximum Daily Benefit Amount. Each increase will be five percent (5%) of the Maximum Daily Benefit Amount in effect on the day before the increase. The benefit increases will also apply to any amounts You are receiving for a claim under the Policy, such that the amount You are receiving for a continuing claim will increase each year accordingly.

Termination: This Rider will terminate on the earliest of: (1) the end of the Grace Period while the premium due for the Policy or this Rider remains unpaid; or (2) the date Your Policy terminates; or (3) upon Your written request for termination of this Rider.

This Rider is signed for the Society at Columbus, Ohio

Joseph H. Hoffman

Chief Executive Officer

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NOTICE TO APPLICANT REGARDING REPLACEMENT OF REPLACEMENT OF ACCIDENT AND SICKNESS INSURANCE

According to your [application] [information you have furnished], you intend to lapse or otherwise terminate existing accident and sickness insurance and replace it with a policy to be issued by The Order of United Commercial Travelers of America. For your own information and protection, you should be aware of and seriously consider certain factors that may affect the insurance protection available to you under the new policy.

You may wish to secure the advice of your present insurer or its agent regarding the proposed replacement of your present policy. This is not only your right, but it is also in your best interests to make sure you understand all the relevant factors involved in replacing your present coverage.

If, after due consideration, you still wish to terminate your present policy and replace it with new coverage, be certain to truthfully and completely answer all questions on the application concern your medical/health history. Failure to include all material medical information on an application may provide a basis for the company to deny any future claims and to refund your premium as though your policy had never been in force. After the application has been completed and before you sign it, reread it carefully to be certain that all information has been properly recorded.

_____

(Signature of Agent, Broker or Other Representative)

_____

Print Name and Address of Agent

The above "Notice to Applicant" was delivered to me on:

_____ _____

(Applicant's Signature) **(Date)**

REPL STC

SERFF Tracking Number:	*WAKE-126046170*	*State:*	*Arkansas*
Filing Company:	*The Order of United Commercial Travelers of America*	*State Tracking Number:*	*41666*
Company Tracking Number:	*AMHSTCAR*		
TOI:	*H13I Individual Health - Short Term Care*	*Sub-TOI:*	*H13I.002 Nursing Home*
Product Name:	*Short Term Convalescent Care*		
Project Name/Number:	*UCT/AMHSTCAR*		

Rate Information

Rate data does NOT apply to filing.

SERFF Tracking Number:	*WAKE-126046170*	*State:*	*Arkansas*
Filing Company:	*The Order of United Commercial Travelers of America*	*State Tracking Number:*	*41666*
Company Tracking Number:	*AMHSTCAR*		
TOI:	*H13I Individual Health - Short Term Care*	*Sub-TOI:*	*H13I.002 Nursing Home*
Product Name:	*Short Term Convalescent Care*		
Project Name/Number:	*UCT/AMHSTCAR*		

Supporting Document Schedules

Satisfied -Name: Flesch Certification
Review Status: Approved-Closed 08/05/2009
Comments:
Attachments:
Readability AR.pdf
AR - R&R19 Cert H.pdf
AR - R&R49 Cert H.pdf
CONS NOT.pdf

Satisfied -Name: Application
Review Status: Approved-Closed 08/05/2009
Comments:
Attachment:
STC APP 109 AR.pdf

Satisfied -Name: Health - Actuarial Justification
Review Status: Approved-Closed 08/05/2009
Comments:
Attachment:
ActuarialMemo - GN_rev.pdf

Satisfied -Name: Outline of Coverage
Review Status: Approved-Closed 08/05/2009
Comments:
Attachment:
STC OC 109.pdf

Satisfied -Name: Authorization Letter
Review Status: Approved-Closed 08/05/2009
Comments:
Attachment:

SERFF Tracking Number:	*WAKE-126046170*	*State:*	*Arkansas*
Filing Company:	*The Order of United Commercial Travelers of America*	*State Tracking Number:*	*41666*
Company Tracking Number:	*AMHSTCAR*		
TOI:	*H13I Individual Health - Short Term Care*	*Sub-TOI:*	*H13I.002 Nursing Home*
Product Name:	*Short Term Convalescent Care*		
Project Name/Number:	*UCT/AMHSTCAR*		

UCT - Wakely letter.pdf

READABILITY COMPLIANCE CERTIFICATION

Name and Address of Insurer:

The Order of United Commercial Travelers of America
1801 Watermark Drive, Suite 100
Columbus, Ohio 43215

I hereby certify that the Flesch Reading Ease Test Score of the listed forms are as follows:

Type and/or Title of Form(s)	Form Number(s)	Flesch Score
Short Term Care Insurance Policy	STC 1/09	42.1
Outline of Coverage	STC OC 1/09	41.4
Home Health Care Rider	STC HHC 1/09	46.6
Guaranteed Purchase Option Rider	STC GPO 1/09	43.5
Compound Inflation Protection Rider	STC CI 1/09	46.3
Application	STC APP 1/09 AR	40.0
Replacement Form	REPL-STC	42.0

The type size of the text is at least 10-pointed leaded.

I also certify to the best of my knowledge and belief that the form is in compliance with the Insurance Code and with all other applicable requirements of the Insurance Department in this state.

Signature

Joseph H. Hoffman
Name

Chief Executive Officer
Title

ARKANSAS
Rule and Regulation 19 Certification

Title of Form(s)	Form Number
Short Term Care Insurance Policy	STC 1/09
Outline of Coverage	STC OC 1/09
Home Health Care Rider	STC HHC 1/09
Guaranteed Purchase Option Rider	STC GPO 1/09
Compound Inflation Protection Rider	STC CI 1/09
Application	STC APP 1/09 AR
Replacement Form	REPL-STC

I hereby certify that the above noted forms meet the provisions of Rule and Regulation 19, the Unfair Sex Discrimination in the Sale of Insurance.

Signature

Joseph H. Hoffman
Name

Chief Executive Officer
Title

ARKANSAS
Rule and Regulation 49 Certification

Title of Form(s)	Form Number
Short Term Care Insurance Policy	STC 1/09
Outline of Coverage	STC OC 1/09
Home Health Care Rider	STC HHC 1/09
Guaranteed Purchase Option Rider	STC GPO 1/09
Compound Inflation Protection Rider	STC CI 1/09
Application	STC APP 1/09 AR
Replacement Form	REPL-STC

I hereby certify that the above noted forms meet the provisions of Rule and Regulation 49, the Life & Health Guaranty Association Notice.

Signature

Joseph H. Hoffman
Name

Chief Executive Officer
Title

Consumer Notice
The Order of United Commercial Travelers of America

Policyholder Service Office:	**1801 Watermark Drive, Suite 100** **Columbus, Ohio 43215-8619**
Telephone Number:	**800-848-0123**
Name of Agent:	**[Fred Smith]**
Agent Address:	**[123 First Street, Any Town, Arkansas]**
Agent Telephone Number:	**[555-555-1234]**

If we at The Order of United Commercial Travelers of America fail to provide you with reasonable and adequate service, you should feel free to contact:

Arkansas Insurance Department
Consumer Services Division
1200 West Third Street
Little Rock, Arkansas 72201-1904
1-800-852-5494 or 1-501-371-2460

The Order of UNITED COMMERCIAL TRAVELERS OF AMERICA
Home Office: 1800 Watermark Drive, Suite 100, P.O. Box 159019, Columbus, Ohio 43215-8619
(614) 487-9680, Toll-free: (800) 848-0123, Fax: (614) 487-9675 www.uct.org

APPLICATION FOR SHORT TERM CARE INSURANCE POLICY

Requested Effective Date of Policy

APPLICANT				**APPLICANT'S ADDRESS**
Last	*First*		*MI*	*Street:*
AGE	**DATE OF BIRTH**		**SEX**	
	Month	*Day*	*Year*	☐ Male ☐ Female
SOCIAL SECURITY NUMBER				*City:*
				State: *Zip Code:*
				Area Code: *Telephone Number:*

SPOUSE *Last*	*First*	*MI*			
SOCIAL SECURITY NUMBER	**AGE**	**DATE OF BIRTH**			**SEX**
		Month	*Day*	*Year*	☐ Male ☐ Female

Underwriting Risk Classification Question

Have you used any form of tobacco in the past two years? ☐ Yes ☐ No

Has your Spouse used any form of tobacco in the past two years? ☐ Yes ☐ No

Are you a member of The Order of United Commercial Travelers of America? ☐ **Yes** ☐ **No**

Council Name:_____ **Council Location (City & State)** _____

HEALTH QUESTIONS

IF YOU ANSWER "YES" TO ANY OF THE HEALTH QUESTIONS, YOU ARE NOT ELIGIBLE FOR COVERAGE.

		APPLICANT		**SPOUSE**	
1.	Do you require assistance or supervision of any kind to perform activities of daily living such as walking, eating, bathing, dressing, transferring or toileting?	☐ Yes	☐ No	☐ Yes	☐ No
2.	Do you require assistance with shopping, housekeeping or cooking?	☐ Yes	☐ No	☐ Yes	☐ No
3.	During the past two (2) years have you:				
	(a) Been a resident of an assisted living facility or personal care home or been confined to a nursing home, home for the aged, or any facility providing assistance with activities of daily living?	☐ Yes	☐ No	☐ Yes	☐ No
	(b) required any assistance with mobility including the use of a walker, multi-pronged cane, walking aids, wheelchair, or scooter?	☐ Yes	☐ No	☐ Yes	☐ No
4.	Are you currently bedridden, hospitalized or have you been hospitalized two or more times within the past year?	☐ Yes	☐ No	☐ Yes	☐ No
5.	Within the past two years, have you been advised to have kidney dialysis, had a heart attack, stroke or heart valve surgery, been recommended to have surgery but not had such surgery, had or been treated for internal cancer, leukemia or malignant melanoma, Hodgkin's Disease, Parkinson's Disease, disabling arthritis, degenerative bone disease, cirrhosis of the liver, Alzheimer's Disease or alcohol or drug abuse?	☐ Yes	☐ No	☐ Yes	☐ No
6.	Have you had or been told by your physician you needed amputation due to disease, you have emphysema, chronic bronchitis, other chronic lung disease, Myasthenia Gravis, Lupus, Multiple or Amyotrophic Lateral Sclerosis, paralysis, Acquired Immune Deficiency Syndrome (AIDS) or AIDS Related Complex (ARC)?	☐ Yes	☐ No	☐ Yes	☐ No
7.	Do you receive Federal, state or local government financial assistance in any form, such as Supplemental Security Income or Medicaid?	☐ Yes	☐ No	☐ Yes	☐ No
8.	Are you an insulin dependent diabetic?	☐ Yes	☐ No	☐ Yes	☐ No

BENEFIT OPTIONS

☐ **Short Term Care Insurance Policy** **Maximum Daily Benefit Amount:** **$**_____ **Elimination Period** ☐ **0 Days** ☐ **20 Days**

Maximum Benefit Period ☐ **100 Days** ☐ **200 Days** ☐ **360 Days**

Optional Riders ☐ **Home Health Care** ☐ **Compound Inflation Protection**

REPLACEMENT INFORMATION (MUST BE COMPLETED)

	APPLICANT		SPOUSE	
1. Do you or your spouse have another insurance policy in force (including health care service contract or health maintenance organization contract)?	☐ Yes	☐ No	☐ Yes	☐ No
2. Did you have another limited benefit policy in force during the last six (6) months?	☐ Yes	☐ No	☐ Yes	☐ No

If yes, with which company: (Name and address): _____

_____

Policy Number: _____ If that policy lapsed, when did it lapse? _____

Daily Benefit Amount : $_____ Benefit Period _____

Do you intend to replace any of your medical or health insurance coverage with this policy? ☐ Yes ☐ No ☐ Yes ☐ No
If yes, please read and sign the replacement notice provided by the agent.

AUTHORIZATION
MUST BE COMPLETED AND SIGNED

WARNING: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for Insurance is guilty of a crime and may be subject to fines and confinement in prison.

Signature of Applicant	**Date**
Signature of Spouse (If applying for separate policy)	**Date**

REASON FOR DISCLOSURE

I understand that the information requested is necessary for evaluation of my application and underwriting of my application for the Insurance Policy for which I have applied; to determine eligibility for insurance, risk rating or policy issuance determinations; obtain reinsurance, administer claims and determine or fulfill responsibility for coverage and provision of benefits; and to conduct other legally permissible activities that relate to any coverage I have, or have applied for, with The Order of United Commercial Travelers of America (UCT). I understand that failure to provide the authorization to The Order of United Commercial Travelers of America (UCT) *will* result in the rejection of the Insurance Policy coverage. I understand that I may revoke this authorization at any time by notifying The Order of United Commercial Travelers of America (UCT) in writing at their Home Office: 1801 Watermark Drive, Suite 100, P.O. Box 159019, Columbus, Ohio 43215-8619. I understand that such revocation will not have any effect on actions The Order of United Commercial Travelers of America (UCT) took prior to their receiving the revocation notice. I understand that this authorization will be valid for twenty-four (24) months from the date signed if used in connection with an application for an insurance policy, reinstatement of an insurance policy, change in policy benefits; or for the duration of a claim if used for the purpose of collecting information with a claim for benefits under the policy. A photocopy of this authorization will be treated in the same manner as the original.

Signature of Applicant	**Date**
Signature of Spouse (If applying for separate policy)	**Date**

AGENT'S CERTIFICATION

The undersigned Agent certifies that the Applicant has read, or has had read to them, the completed application and that the Applicant realizes that any false statement or misrepresentation in the application may result in loss of coverage under the policy.

TO BE COMPLETED BY AGENT (Attach separate sheet, if necessary)

1. List any other health insurance policy you have sold to the Applicant or Spouse that is still in force.

_____
_____
_____
_____

2. List any other health insurance policy you have sold to the Applicant or Spouse in the past five (5) years that is no longer in force.

_____
_____
_____
_____

I certify that:

1. I have accurately recorded the information supplied by the Applicant and Spouse (If applying for separate policy); and
2. I have given an outline of coverage for the policy applied for to the Applicant and Spouse (If applying for separate policy).

Agent's Signature	**Date**
Agent's Printed Name	**Agent No.**

PLEASE SELECT THE METHOD OF PAYMENT YOU WANT

☐ Annual ☐ Semiannual ☐ Quarterly ☐ Monthly EFT

PREMIUM CALCULATION

	Applicant	**Spouse**
Short Term Care Only Premium	**$**	**$**
Home Health Care Rider Premium	**$**	**$**
Compound Inflation Protection Rider Premium	**$**	**$**
SUBTOTAL	**$**	**$**
Less Spousal Discount (If Applicable)	**$**	**$**
Less Non-Tobacco Discount (If Applicable)	**$**	**$**
TOTAL MODAL PREMIUM	**$**	**$**
Modal Fraternal Dues (If Applicable)	**$**	**$**
TOTAL MODAL AMOUNT DUE	**$**	**$**

TOTAL AMOUNT PAID WITH APPLICATION **$** _____

AUTHORITY TO HONOR PREMIUM CHECKS - ATTACH VOIDED CHECK
Deposit Slips NOT Accepted

AUTHORIZATION

IN FAVOR OF: **The Order of United Commercial Travelers of America**
1801 Watermark Drive, Suite 100, Box 159019, Columbus, Ohio 43215-8619.

Name of Bank Customer:

Insured's Name: _____

Account Number: _____ **Routing Number:** _____

To (Name of Bank): _____
Address of Bank:

You are hereby authorized, as a convenience to me, to honor and charge my account for checks, drafts and other orders, including without limitation any order initiated by electronic means, drawn by The Order of United Commercial Travelers of America indicated above, on my account by and payable to the order of The Order of United Commercial Travelers of America for the payment of premiums provided there are sufficient collected funds in such account to pay the same upon presentation. I agree that your rights in respect to each such check or other order drawn by The Order of United Commercial Travelers of America shall be the same as if it were a check drawn on you and signed personally by me. This authority is to remain in effect until revoked by me in writing, and until you actually receive such notice I agree that you shall be fully protected in honoring any such check or other orders drawn by The Order of United Commercial Travelers of America. I further agree that if any such checks or other orders drawn by The Order of United Commercial Travelers of America be dishonored, whether with or without cause and whether intentionally or inadvertently, you shall be under no liability whatsoever even though such dishonor results in forfeiture of insurance.

Date	**Signature of Bank Customer**

AUTHORIZATION

Signature must be the same as on the signature card at bank, and if a company account the name of the account must be shown.

To: Bank above:

In consideration of your compliance with the individual authorization of your depositors to pay checks, drafts or orders, drawn and signed by us to our Order, we agree:

- To indemnify you and hold you harmless from any loss you may suffer as a consequence of your actions resulting from or in connection with the execution and issuance of any check, draft or order, whether or not genuine, purporting to be executed and received by you in the regular course of business for the purpose of payment of such insurance premiums including any costs or expenses reasonably incurred in connection therewith.
- In the event that any such check, draft or order shall be dishonored, whether with or without cause, and whether intentionally or inadvertently, to indemnify you for such loss even though dishonor results in forfeiture of the insurance.
- To defend at our own cost and expense any action which might be brought by any depositor or any other persons because of your actions taken pursuant to said authorization and direction or in any manner arising by reason of your participation in this plan of premium collection.

ACTUARIAL MEMORANDUM

United Commercial Travelers
Short-Term Convalescent Care Policy and Riders

Policy/Rider Forms	Description
STC 1/09	Base Policy
STC OC 1/09	Outline of Coverage
STC CI 1/09	Compound Inflation Protection Rider
STC GPO 1/09	Guaranteed Purchase Option Rider
STC HHC 1/09	Home Health Care Rider
STC APP 1/09	Application

I. Purpose of Filing

The purpose of this rate filing is to demonstrate that for the above-referenced policy the anticipated loss ratio meets minimum state requirements. This rate filing is not intended to be used for other purposes.

II. Coverage Type

This policy provides limited benefits for short term confinement in a facility and other benefits specified in the policy. Coverage is not intended to be long term care insurance according to state insurance laws and regulations.

III. Renewability

Coverage provided by the policies and riders is guaranteed renewable for life subject to the company's right to change premium rates on a class basis.

IV. Premium Structure

Premium rates are level for the lifetime of the coverage and have been determined with the intention that premiums will remain adequate without the need for any rate increases. Premium rates are charged per $10 maximum daily benefit and vary based upon tobacco use, original issue age and benefit option selected. Additionally, a Spousal Discount of 10% is available when an insured and spouse are both issued coverage or 5% is available when only an insured is issued coverage.

The premium rates are attached to this actuarial memorandum.

V. Underwriting and Issue Age Limits

Underwriting is on an accept/reject basis based on the criteria administered through the application and phone interviews. Level issue age premium rates are available for issue ages 50-85.

VI. Qualifying for Benefits

In order to qualify for benefits an insured must be certified by a Licensed Health Care Practitioner as:

1) Being unable to perform (without Substantial Assistance from another individual) at least two of six ADLs (Bathing, Continence, Dressing, Eating, Toileting and Transferring) for a period of at least 90 days due to a loss of functional capacity, or
2) Requiring Substantial Supervision to protect such individual from threats to health and safety due to Severe Cognitive Impairment.

VII. Policy Benefits

The insured selects from the following benefit options at time of issue:

Daily Benefit Amount – $50 to $300.
Elimination Period – 0 or 20 Days.
Maximum Benefit Period – 100, 200 or 360 Days of Covered Services.
Lifetime Maximum Benefit Period – three times the Maximum Benefit Period.

Period of Care – the first day benefits are paid for a Facility confinement (or the first day benefits are paid for either, a Facility confinement or Home Health Care, if the optional Home Health Care Rider is elected). A Period of Care ends, if for a period of 180 consecutive days:

1. You have not met the requirements for benefit eligibility; and
2. Your Physician certifies that You did not require and have not been advised to be confined in a Facility or been advised to receive Home Health Care Services during the 180 day period; and
3. You have not been confined in a Facility or received Home Health Care Services for the 180 day period.

A. Covered Services

Once the Elimination Period has been satisfied, the policy pays the actual charges incurred up to the Daily Benefit Amount for each day an insured is confined in a Facility. A Facility includes a Nursing Home Facility or an Assisted Living Facility. A Facility does not include a hospital, your home, an Alzheimer's Facility, or an Adult Foster Care Facility.

B. Home Health Care Rider

If this optional rider is elected, covered services are modified to include Home Health Care services. Once the Elimination Period has been satisfied, the policy pays 100% of the actual charges incurred up to the Daily Benefit Amount for each day that the insured incurs charges for Home Health Care or Adult Day Care. Home Health Care includes Homemaker Services. Home Health Care does not include services provided while confined in a Hospital, Long-Term Care Facility, Hospice Care Facility, or any other facility that charges for room and board.

C. 5% Compound Inflation Protection Rider

This rider increases the insured's Daily Benefit Amount by 5% compounded annually of the amount in effect on the previous policy anniversary. The Daily Benefit Amount will continue to increase for the life of the policy.

D. Guaranteed Purchase Option Rider

This rider will be provided to insureds that do not select an inflation protection rider. For these insureds, GPO increases will be offered every three years on the Policy Anniversary. If an insured declines to purchase a GPO increase, no additional offerings will be made. Additional premium is due based on the attained age of the insured and premium rate at the time the increase is effective. Each increase is equal to 15% of the Daily Benefit Amount in effect at the time of the offering. No increases are available if insured is in claim status or eligible for benefits. No offers are available after age 85. No commissions will be paid on GPO increases.

VIII. Gross Premium Assumptions

This policy has been priced using the following gross premium assumptions:

1. Mortality

100% of the loaded 1994 GAM Tables (blended 40% male/60% female).

2. Interest

Net investment income of 5.5% all policy years.

3. Voluntary Lapse Rates

The voluntary lapse rates assumed are as follows:

Policy Year		Voluntary Lapse Rate
1		10.0%
2		6.0%
3		4.0%
4		3.0%
5+		2.0%

4. Claim Costs

Claim costs used in pricing were developed from:

a. Tabulations from the Reports of the Society of Actuaries based on the 1985 National Nursing Home Survey Utilization data in Transactions, Society of Actuaries, 1988-89-90 Reports.

b. The 1982, 1984 and 1989 National LTC Surveys.

c. Statistics published by gerontological researchers concerning cognitive and functional impairment prevalence rates and recovery rates.

d. Wakely Actuarial Services, Inc client company experience

5. Percent of Premium Expenses

Percent of premium expenses assumed are as follows:

Policy Year		Commissions*	Home Office & Administration
1		70.0%	18.0%
2		15.0%	10.0%
3		15.0%	10.0%
4-5		15.0%	10.0%
6-10		15.0%	10.0%
11+		5.0%	10.0%

* Commissions are not payable on GPO increases.

6. Per Policy Expenses

Underwriting and Issue expenses: $90 per policy issued.

7. Reserves

a. Statutory reserves – 1 Year FPT at 4.0% interest, 100% of 1994 GAM (loaded) mortality and voluntary lapse rates as follows:

Policy Years 1: Lesser of 80% of pricing lapse rates and 6%;
Policy Years 2-3: Lesser of 80% of pricing lapse rates and 4%;
Policy Years 4+: Lesser of 100% of pricing lapse rates and 2%.

b. Tax reserves – Same as Statutory.

8. Target Surplus

25% of collected premium plus 3% of total reserves.

9. Modal Assumption

10% annual mode/90% monthly mode, no modal loading factors.

10. Distribution of Business Assumptions (percent policies issued)

a. Distribution by Age:

Issue Age		Distribution
50-54		2.00%
55-59		3.00%
60-64		5.00%
65-69		10.00%
70-74		35.00%
75-79		30.00%
80-85		15.00%
Average Age		75

b. Distribution by Maximum Benefit Period:

Benefit Period		Percentage Electing
100 Days		12.5%
200 Days		37.5%
360 Days		50.0%

c. Distribution by Elimination Period:

Benefit Period		Percentage Electing
0 Days		50%
20 Days		50%

d. Distribution by Spousal Discount:

Marital Status		Distribution
Single		50%
Married (1 Issued)		15%
Married (2 Issued)		35%

e. Distribution by Tobacco/Non-Tobacco:

Tobacco Status		Distribution
Tobacco		10%
Non-Tobacco		90%

f. Distribution by Rider:

Rider		Distribution
Home Health Care Rider		50%
5% Compound Inflation Protection Rider		20%

g. Average Daily Benefit:

$100/Day

11. <u>Average Annualized Premium</u>

The average annualized premium expected per life is approximately $1,144.

IX. Lifetime Anticipated Loss Ratio

The lifetime anticipated loss ratio is calculated over a 40-year projection period as follows:

$$\frac{\text{Present Value of Incurred Claims}}{\text{Present Value of Premiums}}$$

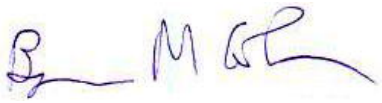
The present values are calculated using a discount interest rate of 5.5% and take into consideration policy terminations. Incurred Claims equal paid claims plus the change in claim reserves. Incurred Claims do not include the change in active life reserves.

The lifetime anticipated loss ratio for this product is over 60% and therefore exceeds the minimum state requirements for this type of coverage. Expected loss ratios by duration over the projection period are attached to this memorandum.

X. Actuarial Certification

I hereby certify that, to the best of my knowledge and judgment, this rate submission is in compliance with the applicable laws and regulations of the state in which it is filed. Furthermore, the actuarial assumptions used are appropriate, the active life reserves make good and sufficient provision to meet future policy obligations as projected, and the benefits are reasonable in relation to the premiums.

Respectfully submitted,



Benjamin M. Cohen, FSA, MAAA
Principal & Consulting Actuary
Wakely Actuarial Services, Inc.
January 28, 2009

Attachments:
Exhibit A – Gross Annual Premiums
Exhibit B – Anticipated Loss Ratios

United Commercial Travelers

Convalescent Care Policy Gross Annual Premiums per $10 Daily Benefit
(Individual Premium Rates)

	100 Day BP Option		200 Day BP Option		360 Day BP Option		5% Compound
Issue	Base	HHC	Base	HHC	Base	HHC	Inflation Rider
Age	Policy	Rider	Policy	Rider	Policy	Rider	Factor
50-54	7.0	4.0	13.0	6.0	23.0	11.0	3.71
55-59	8.0	4.0	15.0	8.0	27.0	13.0	3.30
60	10.0	5.0	18.0	10.0	31.0	15.0	3.03
61	11.0	6.0	21.0	11.0	35.0	18.0	2.87
62	13.0	7.0	23.0	12.0	39.0	20.0	2.80
63	14.0	7.0	25.0	13.0	43.0	22.0	2.69
64	15.0	8.0	27.0	14.0	47.0	24.0	2.60
65	18.0	9.0	30.0	15.0	52.0	26.0	2.49
66	19.0	9.0	32.0	16.0	56.0	28.0	2.41
67	20.0	10.0	33.0	17.0	58.0	29.0	2.30
68	21.0	10.0	36.0	18.0	62.0	31.0	2.26
69	22.0	11.0	38.0	19.0	66.0	33.0	2.19
70	23.0	11.0	40.0	21.0	70.0	35.0	2.12
71	26.0	13.0	45.0	23.0	78.0	39.0	2.03
72	29.0	14.0	50.0	25.0	87.0	43.0	1.99
73	32.0	16.0	55.0	28.0	95.0	47.0	1.90
74	35.0	18.0	62.0	31.0	107.0	54.0	1.79
75	39.0	20.0	69.0	35.0	119.0	60.0	1.68
76	43.0	22.0	76.0	38.0	132.0	66.0	1.60
77	47.0	24.0	83.0	42.0	144.0	72.0	1.53
78	52.0	26.0	91.0	45.0	157.0	78.0	1.49
79	56.0	28.0	97.0	49.0	169.0	84.0	1.46
80	60.0	30.0	105.0	53.0	181.0	91.0	1.44
81	64.0	32.0	111.0	56.0	194.0	97.0	1.42
82	69.0	35.0	121.0	60.0	210.0	105.0	1.38
83	75.0	38.0	131.0	66.0	227.0	113.0	1.36
84	81.0	41.0	143.0	71.0	247.0	124.0	1.32
85	89.0	44.0	154.0	78.0	268.0	134.0	1.30

10% spousal discount - both issued
5% spousal discount -one issued
10% Non-Tobacco discount applies

Elimation Period	Factor
0 DAY	1.15
20 DAY	1.00

EXHIBIT B -- ANTICIPATED LOSS RATIOS

UNITED COMMERCIAL TRAVELERS

Policy Year	Expected Earned Premiums	Expected Incurred Claims	Expected Incurred Claim Loss Ratio
1	3,091,985	512,643	16.6%
2	2,725,214	683,615	25.1%
3	2,477,158	882,013	35.6%
4	2,280,539	922,833	40.5%
5	2,112,001	972,082	46.0%
6	1,958,283	1,026,126	52.4%
7	1,805,970	1,053,893	58.4%
8	1,655,923	1,078,081	65.1%
9	1,509,139	1,098,240	72.8%
10	1,366,520	1,113,882	81.5%
11	1,228,875	1,124,467	91.5%
12	1,096,998	1,102,123	100.5%
13	971,754	1,073,815	110.5%
14	853,993	1,040,024	121.8%
15	744,405	1,001,356	134.5%
16	643,465	958,448	149.0%
17	551,421	891,678	161.7%
18	468,345	823,909	175.9%
19	394,188	756,021	191.8%
20	328,772	689,017	209.6%
21	271,771	623,876	229.6%
22	222,693	552,406	248.1%
23	180,918	486,460	268.9%
24	145,773	426,203	292.4%
25	116,565	371,778	318.9%
26	92,584	323,214	349.1%
27	73,109	273,460	374.0%
28	57,446	231,348	402.7%
29	44,964	196,004	435.9%
30	35,104	166,579	474.5%
31	27,372	142,222	519.6%
32	21,334	119,346	559.4%
33	16,625	100,673	605.5%
34	12,958	85,368	658.8%
35	10,104	72,756	720.1%
36	7,881	62,277	790.2%
37	6,144	52,305	851.3%
38	4,780	43,956	919.7%
39	3,702	36,878	996.1%
40	2,852	30,828	1081.0%
Present Values @ 5.5%:	20,884,350	12,564,539	60.16%

THE ORDER OF
UNITED COMMERCIAL TRAVELERS OF AMERICA
1801 WATERMARK DRIVE, SUITE 100, P.O. BOX 159019, COLUMBUS, OH 43215-8619
(614) 487-9680 • TOLL-FREE: (800) 848-0123 • FAX: (614) 487-9675 • www.uct.org

SHORT TERM CARE INSURANCE POLICY

OUTLINE OF COVERAGE
POLICY FORM STC 1/09

THE POLICY PROVIDES LIMITED BENEFITS

THE POLICY IS NOT A LONG TERM CARE INSURANCE POLICY ACCORDING TO STATE INSURANCE LAWS AND REGULATIONS

READ YOUR POLICY CAREFULLY - This outline of coverage provides a very brief description of some of the important features of the policy. This is not the insurance contract and only the actual policy provisions will control. The policy itself sets forth, in detail, the rights and obligations of both you and the Company. It is, therefore, important that you **READ YOUR POLICY CAREFULLY!**

LIMITED BENEFIT INSURANCE COVERAGE - The policy is designed to provide benefits for convalescent care in a facility that provides nursing care or other benefits specified in the policy.

BENEFITS

Facility Confinement Benefit

Once the Elimination Period is satisfied under the policy, we will pay the actual charges incurred up to the Maximum Daily Benefit Amount for each day you are confined in a Facility.

Bed Reservation Benefit

Once the Elimination Period is satisfied, we will pay the actual charges incurred up to the Maximum Daily Benefit Amount for fees charged to reserve a bed by a Facility when You are absent for any reason during the course of an eligible confinement. This benefit is limited to twenty-one (21) days per Period of Care. Benefits payments will count toward the Maximum Benefit Period.

Qualifying For Benefits

To receive benefits under the policy, the following requirements must be met:

1. The policy must be in force on the date Covered Services are received; and
2. A Physician must certify that:
   a) You are unable to perform at least two (2) Activities of Daily Living without Hands On Assistance or Standby Assistance; or
   b) You have a Cognitive Impairment and require Substantial Supervision.

Limitations On Benefits

Benefits under the policy will not be paid during the Elimination Period and are subject to the Lifetime Maximum Benefit Period.

Important Definitions

Activities of Daily Living means the basic human functions required for you to remain independent. For the purposes of the policy, Activities of Daily Living are as follows: bathing, continence, dressing, eating, toileting and transferring.

Cognitive Impairment means a deficiency in a person's short or long-term memory, orientation as to person, place and time, deductive or abstract reasoning or judgment as it relates to safety awareness. Cognitive Impairment is measured by clinical evidence and standardized tests and is based on your impairment as indicated by loss in the following areas:

1. short or long term memory; or
2. recognition of who or where You are; or time of day, month or year; or your deductive or abstract reasoning.

Covered Services means confinement in a Facility (as defined in the policy). Covered Services will be modified to include in Home Health Care, if the optional Home Health Care Rider is listed on the policy schedule page and the premium for the rider is paid.

Elimination Period means the number of Facility Confinement days (or any combination of Facility Confinement care days and Home Health Care days, if the Home Health Care Rider is elected), for which benefits are not payable under the policy. Days counted toward the Elimination Period need not be consecutive. The Elimination Period is shown on the Policy Schedule Page. The Elimination Period must be satisfied only once during the Insured's lifetime and can only be satisfied by days on which you incur charges for which payment would be made under the policy if there were no Elimination Period.

Facility means a facility that provides ongoing care and related services to at least five (5) inpatients in one (1) location and meets all of the following standards:

1. it is licensed by the appropriate licensing agency, if the state in which it operates licenses such facilities; and
2. it is operated pursuant to law; and
3. it is primarily engaged in providing, in addition to room and board accommodations, nursing care (skilled, intermediate or custodial) by or under the supervision of a duly licensed Physician; and
4. it provides twenty-four (24) hour a day care and services sufficient to support needs of persons who require nursing care; and
5. it has appropriate methods and procedures for handling and administering drugs and biologicals; and
6. it maintains a daily medical record of each patient.

A Facility includes a long term care facility, a nursing home facility or an assisted living facility.

A Facility IS NOT: a hospital, Your Home, and Alzheimer's Facility, an adult foster care facility, a facility or part thereof used primarily for rest; or a home or facility for the aged or for the care and treatment of drug and alcohol abuse; or a home or facility used for the care and treatment of Mental or Nervous Disorders or educational care.

Hands On Assistance means the physical assistance of another person without which you would be unable to perform an Activity of Daily Living.

Home means your private residence, home for the retired or aged, or a place providing residential care, including an assisted living facility, an adult congregate living facility or a personal care facility.

Lifetime Maximum Benefit Period means the maximum number of Facility confinement days (or any combination of Facility confinement days and Home Health Care days, if the Home Health Care Rider is elected) for which benefits are payable under the policy. The Lifetime Maximum Benefit Period is shown on the Policy Schedule Page and is equal to three (3) times the Maximum Benefit Period.

Maximum Benefit Period means the maximum number of Facility confinement days (or any combination of Facility confinement days and Home Health Care days, if the Home Health Care Rider is elected) for which benefits are payable under the policy per Period of Care. The Maximum Benefit Period is shown on the Policy Schedule Page.

Maximum Daily Benefit Amount means the maximum amount payable for any one day of benefits provided under the policy. The Maximum Daily Benefit Amount is shown on the Policy Schedule Page.

Important Definitions

Period of Care means the first day benefits are paid for a Facility confinement (or the first day benefits are paid for either, a Facility confinement or Home Health Care, if the optional Home Health Care Rider is elected). A Period of Care ends, if for a period of 180 consecutive days:

1. You have not met the requirements for benefit eligibility; and
2. Your Physician certifies that You did not require and have not been advised to be confined in a Facility or to receive Home Health Care for the 180 day period; and
3. You have not been confined in a Facility or received Home Health Care for the 180 day period.

Physician means a licensed practitioner of the healing arts operating within the scope of his or her license who is other than a member of your immediate family.

Standby Assistance means the presence of another person within arm's reach of you that is necessary to prevent, by physical intervention, injury to you while you are performing an Activity of Daily Living.

Substantial Supervision means continual supervision, which may include cueing by verbal prompting, gestures, or other demonstrations by another person that is necessary to protect You from threats to your health or safety.

Exclusions: We will not pay benefits for that portion of any expense which is:

1. caused by Mental or Nervous Disorder, without demonstrable organic disease **(NOTE: ALZHEIMER'S DISEASE AND OTHER ORGANIC BRAIN SYNDROMES ARE COVERED BY THIS POLICY AS ANY OTHER SICKNESS);** or
2. caused by alcoholism or drug addiction; or
3. caused by illness, treatment or medical conditions arising out of:
   a) war or act of war (whether declared or undeclared); or
   b) participation in a felony, riot or insurrection; or
   c) service in the armed forces or units auxiliary thereto; or
   d) suicide (while sane or insane), attempted suicide or intentionally self-inflicted injury; or
4. for treatment provided in a government facility (unless otherwise required by law), services for which benefits are available under Medicare or other governmental program (except Medicaid), any state or federal workers' compensation, employer's liability or occupational disease law, or any motor vehicle no-fault law; or
5. for services provided by a member of Your Immediate Family ; or
6. for services for which no charge is normally made in the absence of insurance; or
7. for care received outside the United States or its territories.

Guaranteed Renewable For Life - Premium Subject To Change. The policy is renewable as long as you live, provided you continue to pay premiums when due. At no time while you continue your policy in force, may we place any restrictive riders on your coverage. We cannot cancel or refuse to renew the policy. Your premiums will not increase due to a change in your age or health. We can, however, change your premiums but only if we change premiums for all policies in the same premium class with the same policy form number in your state. We must give you at least thirty (30) days written notice before we change your premiums.

Premium.

You have selected the following benefits for the Base Policy:

Maximum Daily Benefit Amount	**$_____**
Elimination Period	**_____Days**
Maximum Benefit Period	**_____Days**
Lifetime Maximum Benefit Period	**_____Days**

Check **[X]** for one of the following **Base Policy Option and Optional Riders** applied for:

[ ] The annual premium for the **Base Policy Form** **$** _____

[ ] The annual premium for the **Base Policy Form With the Compound Inflation Protection Rider** **$** _____

[ ] The annual premium for the **Base Policy Form With the Guaranteed Purchase Option Rider** **$** _____

[ ] **Home Health Care Rider** **$** _____

TOTAL ANNUAL PREMIUM **$** _____

THE ORDER OF
UNITED
COMMERCIAL
TRAVELERS
OF AMERICA

A Fraternal Benefit Society
PEOPLE HELPING PEOPLE

Home Office:
1801 Watermark Drive, Suite 100, P.O. Box 159019
Columbus, OH 43215-8619
(614) 487-9680 • Toll-free: (800) 848-0123 • Fax: (614) 487-9675
Visit our web site at www.uct.org

January 15, 2009

J. Steven Keck, FSA, MAAA
Wakely Actuarial
34125 US Highway 19 North, Suite 310
Palm Harbor, FL 34684

Dear Mr. Keck:

Wakely Actuarial is hereby authorized to perform filings on behalf of The Order of United Commercial Travelers of America.

Thank you.

Sincerely,

Ronald A. Ives
Vice President of Operations